A MANUAL OF PRACTICAL NURSING

BRIDGE

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OF

PRACTICAL NURSING

Prepared for the

Washington University Training School for Nurses
in the Barnes and St. Louis Children's
Hospitals

EDITED BY

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PREFACE.

This handbook has been prepared to supplement the text-book used by the pupils of the Washington University Training School for Nurses. It is hoped that it will facilitate and render more accurate the work of student nurses.

The routine is that in use by the various services of the Barnes and St. Louis Children's Hospitals.

H. L. B.

HANDBOOK OF

PRACTICAL NURSING

Concerning the Admission of Patients.

1. *General Considerations.*

Nurse in charge to report case to interne at once. Treat all new patients as bed patients until further orders. Weigh and measure height of each patient on admission. Record weight weekly and upon discharge. Give no food until diet and preliminary treatment have been ordered. Take temperature by mouth and when in bed, per rectum. The latter is to be recorded as the admission temperature. All patients are to be bathed on admission, per physician's orders, and are to have a shampoo.

A skin case should not be bathed until after the patient has been examined by the dermatologist.

Upon the admission of a new patient, the nurse who receives him shall immediately verify the admission slip and make any necessary corrections. All such corrections should be reported immediately to the office and the admission slip turned in.

2. *Care of Clothes.*

Upon the admission of a new patient to a ward the following rules are to be carried out.

(a.) The patient's clothes are to be removed and counted by two nurses (one the nurse in charge), in the presence of the patient.

(b.) A correct list of these is to be made, on which is to be recorded the name of the patient, register number, date of admission, and number of the ward.

(c.) This list is to be signed by the *two nurses* counting the clothes, and is to be sent to the linen room with the clothes. A duplicate is to be kept in the ward.

(d.) If the clothing of new patients is so soiled as to require laundering, a requisition for the same should be sent to the office of the superintendent of the hospital.

3. *Care of Infected Clothes.*

All infected clothes are to be wrapped in a cloth wet in formalin 1:500 and sent to the mattress sterilizer. No hats or shoes are to be sent to the autoclave. All hats and shoes (and other leather goods), are to be sent to the fumigating room. This room is located in Building No. 4 at the top and east side of the elevator shaft. The key for this can be obtained in the Training School office. Each article taken to the fumigating room should be tagged, and hung separately on hooks provided for that purpose. *Lock the door* and return the key to the Training School office.

The nurse taking the clothes to the fumigating room will be held responsible for taking the same to the linen room on the morning following the fumigation. After clothes have been placed in the

fumigating room, a requisition for the fumigation of the same should be sent to the office of the superintendent of the hospital.

If these articles are infected with pediculi, please state same on requisition.

4. *Care of Valuables.*

All money (in excess of $1.00), and all jewelry (except wedding rings), are to be removed and sent to the auditor's office. The head nurse is to accept all valuables before the orderly takes the patient to the bathroom.

Special envelopes for this purpose may be procured from the front office. These are to bear the patient's name, register number, address, and date of admission. A list of the valuables and money is to be made in the presence of the patient and must appear on the outside of the envelope.

Two nurses (one the nurse in charge), are to count the money and valuables and sign the list on the outside of the envelope. Whenever the patient is able to do so, he should sign the list on the envelope.

5. *Specimen of Urine.*

A specimen of urine is to be sent to the laboratory *as soon after the admission* of a patient as possible. For all medical cases the *first* stool obtained after the admission of a patient is to be sent to the clinical laboratory.

6. *Gynecological Service.*

On the gynecological service the genitals are to be carefully cleansed before the specimen of urine

is secured, and if there is much discharge this cleansing is to include a plain vaginal douche.

Guides for Charting.

1. Always put patient's full name (surname first), date of admission and ward number on each temperature sheet (black ink).

2. The letters "R" and "M" placed at the beginning of the temperature curve will indicate whether the temperature was taken by rectum or mouth. In case a change in the method is made, it is indicated by the letter under the dot when the change occurred.

3. Patient's temperature to be taken *twice* on admission—once immediately by mouth and again when in bed, by rectum. The latter is to be charted as the *admission temperature.*

4. On admission, all patients are to be weighed and their height taken. The same is to be recorded on the chart.

5. All q. 2 hr. temperatures are to be rectal and all q. 4 hr. and b. d. temperatures by mouth, unless otherwise ordered.

6. Patients are *not* to be awakened for *temperatures unless* so ordered.

7. Midnight line (red ink) to be drawn in the middle of the time space. When charts are made b. d., 12 midnight shall be indicated and the line drawn as with q. 4 hr. and q. 2 hr. chart.

8. Chart temperatures, black; pulse, red; respiration (when ordered), green. Hours in red, except 8 a. m. and 8 p. m., in black. When for any rea-

son it is thought necessary to verify a temperature, indicate such a temperature by a "V" under the dot on the chart.

9. Chart "Day of the Disease" in black; chart number of stools and 24 and 12-hour amounts of urine in red. Chart enemata in space for stools and indicate by letter "E." Chart weight and height in base line of sheet.

10. At the beginning of each medication sheet should be, if in order, diet, bath, confinement in bed, T.P.R. and directions for sending specimens to clinical laboratory.

All "standing orders" for medication and care shall be charged as near as possible to time such order was given and shall be transferred to each successive temperature page at top of the medication list so long as they are in force.

When a medicine or care is discontinued it shall be so indicated on the medication list as near as possible to the time, also the order shall be cancelled in red ink on the sheet where the order first appeared and not on intervening sheets. "P.R.N." orders are not to be charted unless given subcutaneously.

11. In the space below normal line, beginning at the first line above the base line, chart (in black): lumbar punctures, widals, blood cultures, white blood counts (when done daily), Wassermanns, to x-ray room, to clinic, proctoscopic, cystoscopic, œsophagoscopic or bronchoscopic examinations, operations, first day up, stitches out, first dressing, hemorrhages, chill, aspiration of chest or abdomen.

12. In space above 102° line, chart in black; sponge and tub baths, numbered 1, 2, 3, etc., in arabic numerals, all medication that is given subcutaneously, intramuscularly, or intravenously, stating drug, dose and method of administration.

13. On admission and discharge note "admission," "discharge," or "transfer" or "died," under the proper time space above 102° line.

14. In noting the method of administration of a drug, the following abbreviations are to be used:

Intravenously ....."Intra V"
Intramuscularly ....."Intra M"
Intraspinously ....."Intra S"
Subcutaneously ....."Sub C"

Regarding Special Charts.

1. Special Charts are to be started per physician's orders.

2. On all special charts should be recorded the T.P.R. medicines administered and total amount of liquid nourishment, urine and stools.

Observations made by the nurse should be recorded in the column for remarks.

3. When an accurate measurement of the fluid intake is required a "fluid chart" should be ordered. For this record the total fluid intake and output is to be accurately measured. Use for this purpose a glass c.c. graduate which is graduated to measure 10 c.c.

4. When a patient develops any unusual symptoms, the nurse in charge is to start a special chart at once.

5. All special charts on the medical service are to be summarized at 7 a. m. if the patient is on a 24-hour specimen of urine. If the patient is on a 12-hour specimen the charts are to be summarized at 7 a. m. and 7 p. m.

6. Special charts are to be started for post-operative cases.

7. All special charts on the surgical and gynecological services are to be summarized at midnight.

Rounds.

1. The nurse in charge is expected to come forward to meet any visiting physician, members of the office staff of the Training School, or visitors.

The senior nurse is responsible for the ward work during rounds. The ward doors should be closed, the patients should be in their places and the charts on the beds during rounds. The wards must be kept as quiet as possible during rounds.

2. Visitors must not be permitted to remain in the wards during rounds. They should be given a seat outside of the ward.

3. While rounds are being made the junior nurses on the wards and nurses from other wards should not interrupt the head nurse except in case of a *grave emergency.*

4. If the head nurse is making rounds with a member of the visiting staff or the resident physician, the senior nurse is to make rounds with any member of the Training School staff who comes to the ward.

Concerning Physician's Orders.

Nurses are to write, in the order book, all orders that physicians give for patients. They must enter therein the date and the time, and at the bottom of the order sign their own name. The doctor will then look over the orders and sign them. *No order may be carried out that has not been signed by a physician* except in a case of great emergency. When writing the orders nurses are cautioned not to comment on them, nor, unless asked, to discuss them in any way, except to ask information about the orders that will make them perfectly clear. *Orders* may be given by telephone to the nurse in charge only in case of great emergency, these orders to be confirmed as soon as possible by a written order in the order book.

The night supervisor (and not pupils on night duty) may receive telephone orders in emergencies, and may receive written orders in a special book kept for that purpose.

During the day the head nurse may receive emergency orders by phone. Student nurses must refer such orders to the supervisor on duty in the Training School office.

Orders for Morphia and Other Sedatives.

"If necessary" orders for morphia and other sedatives, if written before 4 p. m., *are void after 7 p. m.*

Night Nurses.

1. Nurses on night duty must not call a physician without first referring to the night supervisor.

2. Night nurses are not to take telephone orders. All such must be referred to the night supervisor.

3. Report all new cases to the night supervisor at once.

4. Never give an S.O.S. or P.R.N. order without the permission of the night supervisor.

5. Night nurses are to have all charts finished up to 7 a. m. On the medical divisions if the night nurse is unable to complete all of the summaries, the day nurse is to complete them.

6. Night nurses are cautioned to report any change in a patient's condition to the night supervisor.

7. Patients are not to be awakened after 8 p. m. for temperatures and treatments unless so ordered.

8. All corridor and ward lights are to be turned out at 8 p. m. Whenever possible keep all ward doors closed.

9. The night nurse is to see that all patients have their faces and hands washed, teeth and mouths cleansed, and beds put in order by 7 a. m. All extra blankets used during the night are to be folded up and put into closet. Diet kitchens, utensil rooms and bathrooms are to be left in order.

Rules for Medicines.

1. Head nurse makes out all tickets.

2. If medicines have been discontinued, tickets for same must be bent (not torn) and placed on head nurse's desk. New ticket not to be put into the case until it has been compared with order in

book. Nurse giving medicine should *remove* cards and *replace new ones* in medicine case.

3. The nurse who pours the medicine must pass the same to the patients.

4. Nurses giving medicine should read ticket before removing it from the glass.

Medicine Tickets.

q. ½ h. ½ white ticket, 8—8:30—etc.
q. 1 h. white ticket, 8—9—etc.
q. 2 h. white ticket with corners cut, 8—10—12—etc.
q. 4 h. and 8 p. m., red ticket, 8—12—4—8 p. m.
q. 8 h. red ticket with corners cut, 6 a. m.—2 p. m.—10 p. m.
q. 3 h. orange ticket, 8—11—2—5.
q. 6 h. orange ticket with corners cut, 8 a. m.—2 p. m.—8 p. m.
B.D. blue ticket.
O.D. blue ticket with corners cut.
T.I.D. pc. yellow ticket.
T.I.D. ac. green ticket.
Q.I.D. yellow ticket with corners cut 10—2—6—10—Children's Hospital.
5 times a day green tickets with corners cut, 8—12—4—8—4—Children's Hospital.
P.R.N. ½ blue ticket.

Temperatures.

1. B. D.....8 a. m.—8 p. m.
q. 4 hr.....8-12-4
q. 2 hr.....8-10-12, etc.

2. All cases on q. 4 hr. temperatures, unless otherwise ordered.

3. All continuous fevers on q. 2 hr. temperatures.

4. If any patient develops a sudden rise or fall of temperature, take it q. 2 hr.

5. Temperature to be taken q. ½ hr. during a chill until it begins to fall and then q. 2 hr. until discontinued. Same to be recorded on the graphic chart.

6. In case any temperature reads unexpectedly low, or when there is a sudden elevation, verify it at once. Use a different thermometer and keep it in the mouth for five minutes or take a rectal temperature. Chart all such temperatures "V."

7. Count the pulse for one minute.

8. Patients are to be awakened for temperatures after injection of tuberculin (hours as indicated by Tuberculin Routine) unless otherwise ordered.

Temperatures of patients are not to be omitted for the reason that members of the house staff or visitors are with the patient. The nurse should ask the interne working with the patient if she may take the patient's temperature. It is to be omitted only when so indicated by the physician.

Routine Specimens of Urine—Stools—Sputum.

Surgical Service.

1. First specimen after admission.

2. Morning of operation.

3. Morning after operation.

4. All sputum for all patients is to be sent to the clinical laboratory.

Obstetrical Service.

1. First specimen after admission. If in labor the first specimen is to be sent to the clinical laboratory.

2. Bi-weekly, ante-partum.

3. Tenth day, post-partum.

Gynecological Service.

1. Same as surgical.

Medical Service.

1. First specimen after admission.

2. One specimen for each patient three times a week.

3. All sputum for all patients is to be sent to the clinical laboratory.

4. A specimen of stool is to be sent to the clinical laboratory on admission and one each week thereafter.

Children's Hospital.

Medical Ward.

1. On admission.

2. Other specimens as ordered.

3. Stools and sputum as ordered.

Infants' Ward.

1. All infants' stools to be saved until seen by house officer.

Admission Ward.

1. Stools of all infants to be saved until seen by the visiting physician.

Rules for Sending Specimens.

1. All specimens (200 c.c. urine) to be sent to the clinical laboratory by 7 a. m.

2. All tags are to be marked with date, ward, name of patient and the amount.

3. Admission, B.D. 24 hr., operative, post-operative, ante-partum and post-partum specimens are to be so marked.

4. Any unusual specimen (urine, feces, or sputum) that may be obtained is to be saved in the ward until seen by the house officer. On the medical service these specimens are to be sent to the laboratory without an order.

5. Special specimens are to be collected per orders.

6. When a sterile specimen is to be obtained, the patient is to be catheterized.

Visitors.

1. Ward patients are allowed two visitors a day. Visiting hours for the wards are from 2 to 3 p. m. on week days, and from 2 to 4 p. m. on Sundays.

2. Patients in the Private Pavilion may receive as many visitors as they care to if the physician has not ordered otherwise. All visitors are to leave at 9 p. m.

3. Very ill patients are not to receive visitors except on the order of the physician in charge.

Removal of Stains From Linen.

Suggestions.

1. Remove at once. Use proper reagent.

2. If in doubt use cold water first.

3. Use a small amount of the chemical and follow by hot water.

4. Wash out chemical thoroughly.

Solvents.

1. For sugar use boiling water.

2. For grease use (a) soap and warm aq., (b) clean lard, then soap and warm water.

3. For albumen use cold water.

4. For fruit stains use boiling water.

5. For balsam of Peru use kerosene or alcohol.

6. For argyrol use bichloride 1-500.

7. For vaseline use ether or turpentine.

8. For iodine use alcohol or bichloride 1-500.

9. For potassium permanganate use oxalic acid solution.

10. For ink use potassium permanganate. Follow with oxalic acid. If the stain turns brown use hydrochloric acid.

11. For iron rust use hydrochloric acid.

12. For blood use cold water, then warm soapsuds. Spread starch paste over stain on a mattress and allow it to dry. Brush off and repeat S.O.S.

13. For medicine stains use alcohol.

Care of Rubber Goods.

1. *Rubber sheets, pillows, air rings, etc.*

These are to be cleaned by washing with soap and water, then with formalin 1:500, or car-

bolic acid 1-20. After being dried thoroughly, rubber sheets are to be hung up in the bathroom.

2. *Rubber catheters and rectal tubes (soft).*

After using wash out with cold water, scrub with soap and warm water and boil for 3 minutes. *Before using* do not boil catheters and rectal tubes except when giving treatments requiring aseptic precautions.

3. *Stomach Tubes.*

Stomach tubes are to be cleaned like catheters. When not in use keep them hanging up in the bag provided for the same.

4. *Rubber Gloves.*

(a.) Sterilization. Wrap and boil for three minutes and place in bichloride 1:2000. Do not allow gloves to remain in solution longer than is absolutely necessary.

(b.) Cleansing. (1) Wash in cold water. (2) Scrub both inside and out with soap and warm water. (3) If gloves have been used for infected cases, boil for 3 minutes. (4) Dry thoroughly.

5. *Concerning Rubber Tissue.*

To sterilize, scrub with tr. green soap and water for 10 minutes, rinse and soak in bichloride 1:2000 for 24 hours. Rinse with sterile water and keep in sterile normal salt solution.

6. *Silk or Woven Catheters.*

Silk or woven catheters should never be boiled. Before using soak for 30 minutes in bichloride 1:1000. Rinse with sterile water. After using clean with soap and water and sterilize by soaking in bichloride.

Instruments.

1. *Sterilization.*

Boil all dull instruments 10 minutes. Boil all sharp ones for 3 minutes (knives, scissors, curettes, needles). Wrap knife blades in cotton.

2. *Cleansing.*

(a.) Wash in cold water. (b.) Boil for 10 minutes. (c.) Scour with Bon Ami. (d.) Dry thoroughly.

3. *Forceps.*

Forceps used for lifting sterile goods are to be kept in a 2 percent solution of creolin compound. The forceps are to be scoured and boiled and the solution changed O.D. or as often as necessary.

Disinfection of Dishes.

All infected dishes are to be taken from the patient's tray as soon as the latter is taken to the kitchen and immediately put into a sterilizer and boiled for 20 minutes.

Trays used for infected cases are to be marked. These must be washed after each meal with formalin solution 1:500 or carbolic 1:20.

Concerning Disinfection of Excreta.

1. All infectious excretions (urine, stools, sputum), are to be boiled for 20 minutes in the container in which they have been received.

Concerning the Disinfection of Bedding.

1. Infected pillows, mattresses and blankets are to be sent to the mattress sterilizer.

2. Infected linen is to be placed in cold water and boiled for 20 minutes.

Mattresses.

1. The mattresses of all bed patients are to be turned once a week.

2. For cases where there is great danger of soiling the mattress, e. g., where patients are having involuntary defecation and urination, when large quantities of oil are being used in the treatment of a skin case, etc., an old mattress should be procured for use.

3. Infected mattresses, pillows, blankets, clothes, etc. (no rubber or leather goods), are to be sent to the autoclave.

The sterilizer will be run daily as necessary. Articles sent to the sterilizer before 4 p. m. will be ready on the following morning.

Preparation of Dead.

A morgue box kept in each ward should contain:

1. Shroud and shroud sheet.
2. Triangle of shroud muslin.
3. A 2- and 4-inch bandage.
4. Raw cotton.
5. Small piece of absorbent cotton.
6. Old pen holder.
7. Comb and brush.
8. Tooth picks and rubber bands.
9. Straight and safety pins.
10. Soap in dish.

11. Bath towel and wash cloth.

12. Pair of stockings.

After the physician has pronounced the patient dead, the body is to be bathed (if a communicable disease, use formalin 1:1000), hair combed, nails cleaned, eyes closed, jaws supported, rectum packed and cotton pad applied with muslin triangle.

Put on shroud and stockings, tie hands, ankles and knees together and wrap body in shroud sheet. Be sure to put in false teeth as soon as patient has been pronounced dead.

A tag bearing the ward number, name and address of the patient, and the date, should be pinned to the shroud sheet. A similar tag should be fastened on the outside of the mortuary box.

All jewelry should be removed, placed in a property envelope, and sent to the main office for safe keeping. If possible have the relatives of the patient take charge of all clothing or send same with body.

When a patient dies in the operating room, the body is to be taken care of by the ward nurses.

Danger List.

Patients who are seriously ill are to be put on the danger list by the physician in charge. After the order is written in the book, the nurse in charge is to fill out the proper slip and take same to the main office.

The friends of the patient will be notified from the main office.

Care of Wards.

1. All enameled furniture to be washed daily

with soap and water. Clean with Bon Ami as necessary.

2. All polished furniture to be dusted daily with a damp (not wet) cloth or oiled duster.

3. Dust electrical fixtures with a dry duster.

4. Clean nickel with whiting.

5. Use metal polish for brass and copper (except when the metal is lacquered).

6. Clean porcelain with soap, water and Bon Ami.

7. Scrub the inside of all sterilizers daily with soap, water and sapolio.

8. Clean marble with soap, water and Bon Ami. *Never use acids* on marble or tile.

9. To remove white stains from wood, rub with Tr. of Camphor. Follow immediately with oil. Remove grease stains from varnished woods with Ivory soap and water.

10. To remove ink from wood, cover the spot immediately with blotting paper, flour or starch. Repeat until the absorbent no longer becomes stained. Then rub spot with lemon pulp and salt until the stains disappear.

11. The refrigerator should be wiped out daily; twice a week it should be scrubbed out with soap and water.

12. All utensils—bed pans, sputum cups, curved basins, etc., should be rinsed out with cold water, then hot water. Scrub all bed pans and urinals with soap and water, and boil daily. Scour all other utensils immediately after use and boil p.r.n.

Blankets.

1. White blankets are to be used on beds only.

2. Bath blankets are to be used for baths only.

3. Old W.U. or light weight gray blankets are for use in chairs only.

4. Large dark gray blankets are for use on porches.

5. Head blankets are to be used for no other purpose.

Clean-up Tray.

Flask of green soap.
Flask of sterile water.
Flask of ether.
Flask of alcohol, 60 percent.
Bottle of collodion.
Bottle of aromatic spirits of ammonia and medicine glass.
Adhesive.
Camel's hair brushes (sterile in jar).
Toothpick swabs (sterile in jar).
Jar of sterile sponges.
Sterile towels.
Ethyl chloride.
Towels and handkerchiefs.
Dressing rubber and towels.
Rubber tourniquet and clamps.

Examination Tray.

Throat mirror.
Wooden tongue depressors.
Small paper bags.
Flash light.

Tape measure.
Percussion hammer.
Blue and red skin pencil.
Two towels.
Nasal and aural specula.
Auscultation towels.
Gauze handkerchiefs.
Pins.
Glass slides.
Cotton toothpicks.

Vaginal and Rectal Tray.

Pair sterile gloves.
One right glove.
One left glove.
One towel.
One tube vaseline.
One powder box.
Bivalve speculum.
One pair uterine dressing forceps.

Liquid Diet.

Feedings every two hours from 6 a. m. to 8 p. m., and as near every two hours as possible when patient wakes during night.

Whole milk.	Strained soup.
Butter milk.	Fruit juice with water.
Ice cream.	Albumin water.
Cocoa.	Meat juice.
Coffee.	Gruels.
Tea.	Water.

Serve 250 c.c. at each feeding.

Soft Diet.

Three meals daily at 7 a. m., 12 and 5 p. m.

At 10 a. m., 3 and 8 p. m. each, one article from liquid diet list.

Anything on liquid diet list may be served at meal time.

Patients shall not be allowed any food brought by visitors without special permission.

Butter.

Cheese; cream or neuchatel.

Eggs, according to taste (raw, soft-boiled, poached).

Potatoes (white, well cooked), baked, boiled, creamed.

Bread (white only), toast.

Crackers, graham or soda.

Apple sauce.

Cream toast.

Cereals:

- flakes.
- gruels.
- mush.
- oatmeal.
- rice.
- macaroni.
- shredded wheat biscuit.

Puddings:

- bread.
- rice.
- chocolate.
- meal.
- custard.
- tapioca.
- Spanish cream.

Ices or ice cream.

- gelatin.

Light Diet.

Three meals daily, at 7 a. m., 12 and 5 p. m.

At 10 a. m., 3 and 8 p. m. each, one article from liquid diet list.

Anything on liquid or soft diet list may be served at meal time.

Patient should not be allowed any food (except fruit) brought by visitors without special permission.

Meat (small amount once daily):

- Beef, roast.
  - scraped.
  - steak.
  - stew.
- Veal and mutton chops.
  - liver.
  - kidney.
- Poultry.
- Fish (no shell fish).

Vegetables:

- asparagus.
- beans.
- carrots.
- celery.
- corn.
- peas.
- spinach.
- White and sweet potatoes well cooked, baked, boiled or creamed.

Fruits (fresh or canned):

- apples.
- bananas (ripe).
- blackberries.
- cherries.
- grape fruit.
- grapes.
- lemons.
- oranges.
- peaches.
- raspberries.
- strawberries.
- watermelon.

Fruits (dried or stewed):

apricots.	raisins.
prunes.	apples.
figs.	rhubarb.

Bread: brown, buns, graham, corn, rolls, white, zwieback.

Crackers: soda or graham.

Cream toast. Hominy. Cake.

Regular Diet.

Three meals daily, at 7 a. m., 12 and 5 p. m.

At 10 a. m., 3 and 8 p. m. each, one article from liquid diet list.

Anything on light, soft or liquid diet list may be served at meal time.

Food brought to patients, by visitors, shall be turned over to nurses who shall see that it conforms to regular diet.

Meat (average helping once or twice daily) in addition to light diet:

Lamb or mutton.

Fish, including oysters, crabs, clams.

Poultry.

Vegetables:

Beets.

Parsnips.

Squash.

Tomatoes.

Fruit: Fresh, cooked, canned.

Bread; no pastry; may have nuts and condiments.

Cleansing Bath.

Ward Patients.

Three times a week.

Daily at discretion of head nurse.
Daily to all obstetrical patients.
Daily to patients in Children's Hospital.

Private Room Patients.

Daily.

Early Morning Toilet.

All ward patients (and private patients as indicated by the head nurse), are to be made ready for breakfast by the night nurse. This toilet consists in washing the patient's face and hands, cleansing the mouth and straightening the bed.

Morning Toilets to Ward Patients.

Make bed, using fresh linen S.O.S. Change binder and rub back with alcohol and powder S.O.S. Comb hair and clean nails. Cleanse mouth.

Evening Toilets.

Remove pillows, wash face, hands and back. Rub back with alcohol and powder. Tighten bed clothes. Remove all crumbs. Cleanse mouth. Replace pillows.

Care of Mouths.

Routine mouth wash for all patients is Liquor Antiseptic Sol. Alk. dr. 1 to ½ cupful water. Each patient should have a toothbrush. Mouths to be cleansed t.i.d. after meals and in the morning before breakfast. The mouths of patients on liquid nourishment or those running high temperatures require particular care. Give patient water to drink after each nourishment and cleanse mouth, using cotton applicators. For a dry tongue use albolene. Use cold cream for dry lips. Never introduce a finger into a patient's mouth.

Care of Hair.

1. The hair of all patients is to be washed upon admission and as often thereafter as necessary.

2. For pediculi use Tr. of Larkspur or Carbolic 1-20. Wet hair and scalp thoroughly; bind up with towel and leave for 2 hours. Repeat S.O.S. Then wash hair in usual manner.

Sponge Bath for Reduction of Temperature.

Requisites.

One large rubber sheet.
One binder and safety pins.
One muslin draw sheet.
One hot water bottle.
One large basin water 100° F. (unless otherwise ordered).
One bath thermometer.
One ice bag.
One old blanket.

Notes.

The sponge should be given by two nurses and should last ten minutes (20 minutes if one nurse is sponging the patient). Use sufficient friction to keep the blood in the skin. Avoid making pressure on the abdomen when sponging a typhoid fever patient. If the patient is chilly after the sponge, give light friction through a blanket. Take the temperature twenty (20) minutes after the sponge and record the same.

Cold Pack to Reduce Temperature.

Requisites.

Two sheets (wet in water 100° F.).

One long rubber.
One ice bag.
One hot water bottle.
One basin of water 100° F.
One whisk broom.

Notes.

Give friction before putting patient between wet sheets and during bath. Keep sheets wet. Pack is given for twenty minutes.

Cold Pack as a Sedative.

Requisites.

Two blankets.
One long rubber.
Two sheets (wrung out of tap water).
One hot aq. bottle.
One ice cap.

Notes.

Leave patient in pack for one-half (½) hour. Disturb the patient as little as possible in taking out of pack.

Brandt Bath.

Requisites.

Tub ½ full water, 85° F.
Stretcher and hooks for tub.
Rubber ring.
Bath thermometer.
Ice cap.
Bathing cap.
Non-absorbent cotton (for ears).
Binder and safety pins.
Long rubber sheet for bed.

One sheet.
One old thin blanket.
One towel.
One hot water bottle.

Notes.

An orderly should always be secured to assist in lifting the patient into and out of the tub. Two nurses are required to give the bath, which lasts for 15 minutes. During the bath watch the pulse closely. If the patient becomes cyanosed or the pulse becomes weak notify the physician. Give constant friction during the bath. After removing the patient from the tub, dry between sheets and keep him covered with a blanket until warm. Give gentle friction through the blanket and a hot drink if the patient is cold.

Hot Air Bath For Induction of Perspiration.

Requisites.

Eliminator.
Ice bag.
Three old blankets.
One porch blanket.
One abdominal binder.
One bath towel.
One face towel.
One solution thermometer.

Notes.

Record the temperature of the bath q. 10 minutes and keep it between 130 and 140° F. Watch the patient's pulse closely and record it q. 10 minutes. Force fluids during the bath (water, vichy, hot lemonade, etc.). Unless otherwise ordered, leave

the patient in the bath ½ hour after he begins to perspire freely. At the end of that time take him out, give a brisk rub and leave between warm, dry blankets for 1 hour. Then dry the body thoroughly, give a warm alcohol rub and remove the blankets. *Avoid exposing* the patient during or after the bath. The eliminator should be supplied with eight (8) 40 watt carbon lights.

Hot Wet Pack.

Requisites.

Four old blankets.
Two long rubbers.
One foot tub.
Five hot water bottles and covers.
One ice bag.

Notes.

Bath to be given for thirty (30) minutes. Force fluids; watch pulse closely. Follow same general rules in removing patient as in "Hot Air Bath."

Typhoid Routine.

1. Isolation.
2. Force water (200 c.c. q. hr. the minimum). Keep urine output above 1500-3000 c.c.
3. Measure abdomen daily.
4. Tap water enema 75°-80° F. pint 2 q. a. m.
5. Ice bag to abdomen constantly.
6. Ice bag to the head as long as patient complains of headache, has high temperature or is delirious.
7. Record all fluids taken and estimate caloric value of food taken.

8. T.P.R. q. 2 hr.

9. Sponge q. 4 hr. at 100° F. if temperature is above 102.5° F.

10. Care of mouth. Give patient water ten to fifteen minutes before each feeding. Teeth and mouth (special attention to tongue) to be cleansed before and after each feeding with Listerine and water, equal parts. Use Albolene on the tongue and in the nose, and cold cream on the lips.

11. Nurses are to wear gowns while working with a typhoid patient. When giving tub baths, the nurse is to wear a rubber apron.

12. After serving a patient, scrub hands thoroughly with a brush, soap and water and wash them with an alcohol sponge.

13. All dishes, linen and excreta are to be disinfected.

14. Report at once any untoward symptoms, e. g., sharp, sudden pain in abdomen or hemorrhage, to the physician in charge.

Typhoid Routine in the Children's Hospital.

1. Observe 11, 12 and 13 of the preceding routine.

2. Diet:

Soft diet 3 times a day.
Soft boiled egg.
Milk toast, custard.
Ice cream, apple sauce, rice, soft puddings, jelly, toast, soup.
Fifty oz. fluid in 24 hours.
Cocoa, milk, eggnog, water, lemonade, orange juice, orange albumen.
Lactose and cream as ordered.

3. Enema E.O.D. p.r.n.

4. Temperature, per rectum, every four hours, unless otherwise ordered. Mouth washed out every four hours, day and night.

Test Meals.

Dock.

1 shredded wheat biscuit.
400 c.c. water.

Ewald.

2 slices white bread.
400 c.c. water.

Note.

Have patient eat meal rapidly and lie on back after eating.

Test Dinner.

A full dinner with a portion of spinach.

Aspiration of Stomach Contents.

Things needed are the same as for lavage with the addition of a Politzer bag and specimen basin.

Gastric Lavage.

Requisites.

Stomach tube (in basin of cracked ice).
Glass funnel (special).
Pail.
Rubber apron for physician and patient.
Two gauze handkerchiefs.
Towel.
Curved basin.
One large pitcher water at 105° F.

Notes.

Have patient sit up, if possible. Remove false teeth. Give 3-4 hours after meals unless otherwise ordered. If there is any sign of blood in return, discontinue treatment and report to physician in charge.

Gavage.

Same things needed as for lavage with exception of solution and pail. Food per physician's orders.

Nasal Gavage

Requisites.

1. Soft rubber catheter (14-16 F.) with glass connecting tube and 18 in. rubber tubing. Small funnel.

2. Food, per doctor's orders.

3. Notes: Insert catheter, pointing it slightly toward the septum (8-10 in.). Before pouring in the food, hold funnel to ear, to be sure tube is not in the trachea.

Catheterization of Female Patients.

Requisites.

1. Sterile tray containing:
   One small basin sterile water.
   One small basin bichloride 1:2000.
   One glass of Tr. green soap.
   Twelve cotton sponges.
   One glass of sterile glycerine.
   One pair thumb forceps.
   One towel.

One small curved basin.
One urine cylinder and 2 gauze fluffs (if sterile specimen is to be obtained).

2. Catheters. Boil 2 small glass catheters for 10 minutes in catheter sterilizer. Leave catheters in sterilizer in water in which they were boiled. Keep sterilizer closed and introduce nothing into the same.

3. Pair of knee caps.
Large curved basin for urine.
Small curved basin for sponges.
Small blanket for patient's chest if ward is cold.

Notes.

1. Never use a glass catheter for an extremely nervous, irrational or obstetrical case.

2. Inspect catheter carefully before inserting to be sure that it has not been cracked in sterilization.

3. Use sterile glycerine S.O.S.

4. In catheterizing infants and children, use a small rubber catheter instead of a glass one.

Catheterization of Male Patients.

Requisites.

1. Sterile tray:
Prepare same as for female catheterization with the exception of the catheters.

2. Two (2) rubber catheters, No. 18F.

3. Other things (except knee caps) same as for female catheterization.

Bladder Irrigation.

Requisites.

1. Same as for catheterization. In addition have small pieces of rubber on glass catheters.

2. Solution (per physician's orders) at 105° F. Cover can with sterile towel. Have glass connecting point in end of irrigator tubing and have clamp near the end of the tubing. Wrap end of tubing in sterile towel so it can be handled after the hands are scrubbed.

Notes.

Have can not more than 10 inches above level of bed. After catheterizing patient, connect tubing and let solution run into bladder until it feels full, then disconnect and empty the bladder. Repeat process until solution returns clear or at least 2 pints have been used.

Cystoscopic Examination.

Requisites.

1. Requisites for catheterization.
2. Requisites for bladder irrigation.
3. Sterile olive oil.
4. Cystoscope.
5. Urethral dilators.
6. Cocaine or novocaine per physician's orders.

Caution.

Keep cystoscope separate from other things used.

Catheterization of Ureters.

Requisites.

1. Same as for a cystoscopic examination.

2. Two sterile silk elastic catheters for ureters (marked for right and left).

3. Sterile test tubes or bottles (marked for right and left).

Caution.

Keep cystoscope and catheters for ureters separate from other things used.

To Sterilize a Cystoscope.

Scrub with Tr. green soap and water for five minutes. Use a sterile brush.

Soak in 60 percent alcohol for five minutes.

Soak in oxycyanide of mercury 1:1000 for ten minutes.

Note.—If oxycyanide of mercury is not obtainable, soak in pure carbolic for five minutes. Rinse off thoroughly with sterile water. In rinsing the cystoscope place it in sterile basin and pour sterile water over it. Pour this off. Repeat this at least three (3) times, always having cystoscope entirely covered with water.

Collection of 24 Hour-Specimen of Urine.

To be used in all cases other than Metabolism.

The bladder is to be emptied at 6:30 a. m. The urine voided at this time is discarded. In the column for remarks on the special chart should appear the note, "24 hour-specimen begun." The urine voided during the night and day is saved in a large, open-mouthed bottle provided for the same. In each bottle should be put ¼ oz. of chloroform. After each addition of urine to that already in the bottle, it should be shaken gently in order to

bring the urine in contact with the preservative. The bottle should be kept corked. In case urine is "lost with stool," or discarded by mistake, the amount should be estimated and a note explanatory of the same should appear in the column for remarks. Each time the patient voids, the amount and time should appear on the special chart. At 6:30 the next morning the bladder should be emptied and this urine added to that in the bottle to complete the 24 hour-specimen. On the special chart opposite the time at which the last urine was voided should appear the notation, "24 hour-specimen ended." In case urine has been lost or the patient is unable to void at the end of the 24 hours, the note should read, "24 hour-specimen ended, incomplete." The total amount of urine voided should appear in the summary, followed by an interrogation point if inaccurate. In case a 24 hour-specimen is ordered begun immediately after the admission of a patient (ex. at 10 a. m.) the specimen is to be ended per routine at 6:30 the next morning. The night nurse leaves all bottles tagged and ready for the 24 hour-specimen. Each tag should bear the patient's name, the ward number, the date and what is wanted. The summary on the chart should correspond with the summary on the urine tag. If a patient has a phthalein test, or urine is lost, the tag should be made out as follows:

65 c.c. ?	Estimated loss with stools.
400 c.c.	Phthalein test.
1865 c.c.	Total sent to the laboratory.
2330 c.c.	Total output for 24 hours.

Collection of 12 Hour-Specimens of Urine.

Specimens are collected from,
6:30 a. m.—6:30 p. m.
6:30 p. m.—6:30 a. m.

The routine is exactly the same as for the collection of a 24-hour specimen of urine. The night nurse leaves the bottle tagged and ready for the day specimen and the day nurse prepares it for the night specimen.

Collection of Urine in Metabolism Cases.

Time of Collection.

Begin and end 24-hour specimens at 6:30 a. m. Variation should not exceed fifteen minutes. When beginning collection the urine passed at 6:30 a. m. the first day is thrown away, because it belongs to the previous 24 hours. All urine passed until and including 6:30 the next morning is one 24-hour specimen.

Preservation.

The patient should be instructed to call the nurse before passing urine and the specimen should be added to the total specimen immediately. It is of great importance to get the specimen in contact with the preservative. *Bottles* should be clean and corked, and each one should contain one-fourth ounce of chloroform. As each specimen is added to the collection, the bottle should be shaken gently in order to insure the mixture of the urine and chloroform. Well preserved urine is usually *clear,* has no odor, except that of chloroform and the normal urinary odor and is not dis-

agreeable in any way. The nurse should watch the urine herself to see that it is being properly preserved. Only decomposed urine is foul. A decomposed urine means that the nurse is at fault. The following chart should be kept on the bottle and, as the specimens are collected, should be carefully made out and at the end of the 24 hours the head nurse of the ward, or the nurse in charge of the case, should sign this urine chart to the effect that the specimen is complete, or if incomplete that should be stated. Chart must accompany bottle to laboratory:

URINE CHART

6:30 a. m., 12:1 to 6:30 a. m. 12/2.

Ward No. _____ Mr._____

Nurse's Name	Time of Responsibility	Time of Voiding	Amount Voided
Miss X	7-4	10 a. m.	350 c.c.

{Complete / Incomplete} 24 hour specimen. Amount_____c.c.

(Signed) Miss Z.
Head Nurse

Measuring Urine.

Urine should be measured with 500 c.c. or 1,000 c.c. graduates, graduated in 10 c.c. Graduates with sloping sides are undesirable. The total 24-hour specimen should agree with the sum of the separate voidings to within less than 25 c.c.

Sources of Loss.

The most important source of loss is in the stools. The stools should be inspected by the nurse so as to make sure that urine is not lost in this way, and if urine is passed with the stool, a rough estimate should be made of the loss and the amount noted on the chart. Any loss whatever should be estimated on the chart, and on the back of the chart an explanation as to the cause for loss should be noted.

Instructions Which Nurses Give to Metabolism Patients.

Urine.

On entering the Hospital, the nurse in charge of the case with the physician has a frank talk with the patient, explaining the necessity for the exact collection of urine. The following points should be impressed upon the patient by the nurse:

1. Voiding should be made with urinal only.

2. The nurse should be notified immediately on voiding.

3. Always void before going to stool.

4. Under no circumstances should any metabolism patients use the toilet. If patient is up and about, he should use commode; if in bed, the bed-pan.

5. The nurse should urge the patient to completely empty the bladder at the end of the 24-hour specimen, or at 6:30 a. m.

Nurse's Instructions to Patients as Regards Metabolism Diet.

1. Under no circumstances whatever is any food to be eaten that is obtained from outside of the Hospital, or from the trays of other patients. The nurse should tell the patient that if at any time he disobeys this rule, we scarcely can be expected to treat him further.

2. Patient should eat all of the food served, or as much as possible. (The diets will not be excessive in amounts).

3. The head nurse should instruct the patient in the use and adjustment of the correct amount of saccharine.

4. Patients should be weighed every day, as far as possible at a stated time in the morning after urinating, before water or breakfast and *without clothes* or with constant *weighed* clothing (blanket or sheet).

5. It is an important duty of the nurse to become acquainted with the likes and dislikes of a patient, so that as far as possible the diet may be well received by the patient.

Enemata.

S. & G. Enema.

Soapsuds	pints 2
Glycerine	oz. 1 to 3 (av. ℥ii).

M. G. & W. Enema.

Mag. Sulph. Crystals.	oz. 2.
Glycerine	oz. 2.
Water	oz. 2.

Oil Enema.

Warm Cottonseed Oil oz. 6.

Give high and follow in 2 hours with soapsuds enema (per physician's order).

Cold Water Enema.

Tap water (65° F.) oz. 8—pints 1.

Give quickly and have patient expel it as soon as possible.

W. and G. Enema.

Water	oz. 3.
Glycerine	oz. 3.

O. and G. Enema.

Cottonseed Oil	oz. 3.
Glycerine	oz. 3.

Notes.

(1) For all cleansing enemas, when large amounts of fluid are to be given, use can and enema tip.

(2) For all oil enemata, and where small amounts of fluid are to be given, use a funnel and rectal tube.

(3) In giving medicine, per rectum, do not give it in more than 150 c.c. water.

(4) Except in case of "cold water enema," have solution warm.

(5) In giving an enema after a perineorrhaphy, use a small rubber catheter, insert it gen-

tly and direct it toward the posterior rectal wall.

(6) An enema should not be given nor a rectal tube inserted during the first week following a perineal prostatectomy unless so ordered by the attending genito-urinary surgeon.

Asafetida Enema.

Milk of Asafetida dr. 2 to oz. 2 (per physician's order).
Water oz. 8.
Follow in one-half hour with an S.S. Enema.

Turpentine Enemata.

Formula 1:

Turpentine oz. ½ (per physician's order).
Warm oil oz. 8.
Follow in ½ hr. with an S.S. Enema.

Formula 2:

Turpentine dr. 1 to 4 (per physician's order).
Soapsuds pts. 2.
See that turpentine is thoroughly mixed with the soap solution.

Milk and Molasses.

Milk
Molasses } Equal parts, average oz. 6 of each.

Rectal Tubes.

Unless otherwise ordered rectal tubes are not to be left inserted for longer than one-half (½) hour. Insert for a distance of eight inches.

Flaxseed Poultice.

Boiling water one cup.

Flaxseed meal three-quarters cup.

After removing it from the fire, add a pinch of soda to the poultice and beat it vigorously. Vaseline the surface to which the poultice is to be applied. Keep a hot water bottle over the poultice and change it q. 1 hr. or often enough to keep it warm.

Mustard Paste.

For adult—1 part mustard to 3 parts of flour.

For child—1 part mustard to 8 parts flour.

Leave on 20 to 30 minutes. Wash surface with warm water and soap after removing the paste.

Turpentine Stupes.

For adults—1 part turpentine to 2 parts oil.

For children—1 part turpentine to 7 parts oil.

Change stupes q. 10 min., or often enough to keep warm. Apply turpentine and oil q. 3rd or 4th stupe. When the stupes are ordered, ask the physician if he wishes a rectal tube inserted.

Cantharides Plaster.

1. Prepare skin by shaving and scrubbing as for operation.

2. To apply, oil plaster and lay it on the skin and bind in place *loosely*. If blister has not formed at the end of eight hours, report the fact to the physician.

3. After blister has raised remove plaster very carefully; remove any particles of cantharides by washing surface with oil.

4. If blister is to be opened use sterile scissors and puncture blister at its lowest point. Catch the fluid on a sterile sponge. Treat as an open wound.

Concerning Hot Water Bottles.

1. The temperature of water used in filling water bottle is to be 150° F. for adults and 120° F. for children.

2. No hot water bottle is to be used unless it is properly covered.

3. Never apply a hot water bottle without permission from the head nurse. The one exception to this rule is that one may be applied for cold feet.

4. Never leave a hot water bottle in the bed of an unconscious patient without an order.

Foot Bath.

Requisites.

Foot tub one-half full of water at 105° F.
One old blanket.
One bath towel.
One pitcher of water at 130° F.
One bath thermometer.
One hot water bag.

Notes.

Increase the temperature of the water to 112° F. The bath is to be given for one-half hour. Put a hot water bottle to the feet of the patient at the conclusion of the bath.

Mustard Foot Bath.

Requisites.

A foot tub one-half full of water 90-98° F. Mustard oz. ½ to one gal. water. Other things are the same as for an ordinary foot bath.

Preparation of Hands.

For dressings and treatments requiring aseptic precautions.

Scrub with green soap and running water for 5 minutes. Rinse well and soak in alcohol 60 per cent for 3 minutes.

Hypodermoclysis.

Requisites.

One flask saline 112° F. (litre size).
One clysis needle (steam sterilized).
One clysis package containing:
One clysis tube.
One four inch glass tube.
Two gauze squares.
Scrub-up tray.
Hemostat and a gauze bandage.

Notes.

Never introduce anything except clysis tube into the saline flask. Two sterile clysis sets must always be kept in each surgical ward, and one in each medical ward.

Blood Culture.

Requisites.

One sterile tray containing:
Twenty c.c. Luer syringe and needles or large Record needles with rubber tubing.

Sterile sponges and test tubes.

2. Scrub tray.

Preparation of patient: Clean area with Iodine.

Injection of Salvarsan.

Requisites.

1. Sterile tray containing the following articles which have been boiled in distilled water:
   Platinum needle.
   Special piece rubber tubing.
   Salvarsan cylinder.
   Glass stoppered bottle.
   Medicine glass.
   Medicine dropper.
2. Flask salt solution.
   Flask freshly distilled water.
   Dose Salvarsan.
   Bottle 20 percent sodium hydrate.
   Infusion pole.

Preparation of Patient.

Apply Tr. Iodine to area indicated by the physician.

Routine (per physician's orders).

Omit preceding meal. In the a. m. before the treatment, give magnesium sulphate per physician's orders. If the patient is on regular or light diet, give soft diet for the succeeding meal. Take T.P.R. q. 2 hrs. for 24 hrs. after the treatment.

Note.

Sterilize the ampule by placing it in a sterile basin and covering it with 60 percent alcohol.

Intravenous Infusion.

Requisites are same as for Hypodermoclysis with the substitution of canulæ or needles per physician's orders.

Venesection or Phlebotomy.

Requisites.

(1) A sterile tray containing:
- One aneurism needle.
- Two hemostats.
- Two thumb forceps.
- One probe.
- One pair small sharp-pointed scissors.
- One scalpel.
- Two skin needles.
- Twelve sterile sponges.
- Two sterile towels.
- Catgut and silk.
- One curved basin.

(2) Scrub tray.

(3) One c.c. cup (for blood).

Paracentesis.

Requisites.

1. Sterile tray containing:
   - Canula and trocar.
   - Exploring needles with small pieces of rubber tubing.
   - Two Aseptic syringes.
   - Scalpel.
   - Probe.
   - Scissors.
   - Two skin needles and silk sutures.

Thumb forceps.
Twelve cotton sponges.
Two pieces flat gauze.
One special abdominal binder.
One glass funnel and long piece of rubber tubing.

2. Rubber sheet.
Laparotomy stockings.
Two blankets.
Stool for patient's feet.
Pail for fluid.
Scrub tray (with fresh Sod. Citrate Sol.).

3. Novocaine one-half percent and a sterile hypodermic syringe, per physician's orders.

Notes.

Shave abdomen, if necessary, and prepare with Tr. Iodine.

Have the patient void urine immediately before operation.

Have the patient sit up on the side of the bed if possible.

Tuberculin Injection.

Boil in saline solution a hypodermic syringe with needle attached and three medicine glasses. Prepare site of injection with Tr. of iodine.

Routine (per physician's orders).

Give at 8 p. m. The patient then sleeps undisturbed until 6 a. m. After 6 a. m. take temperature q. 2 hrs. unless otherwise ordered. If the patient has been on regular or light diet and the temperature is elevated after the injection, he is to be given soft diet until otherwise ordered.

Lumbar Puncture.

Requisites.

1. Sterile tray containing the following articles which have been sterilized by boiling in distilled water:

One special lumbar puncture needle.
One 10 c.c. Record Syringe.
Two medicine glasses.
One hypo syringe and 2 needles.
One water manometer (as desired by physician).

2. Scrub-up tray and, in addition, the following articles:

Two sterile test tubes.
One bottle of novocaine one-half percent (if desired).
One small flask of saline 110° F.

Preparation of Patient.

1. Turn on side, bring hips to side of bed and bring patient's knees as close to chin as possible.

2. Cleanse skin from lower sacrum to scapula and to posterior axillary lines with Tr. Iodine.

Notes.

1. For Dr. Sach's cases, shave the above area.

2. On the surgical service, have sterile rubber gloves for the physician.

Aspiration With Syringes.

Requisites.

1. Sterile tray containing:
   Two glass syringes with rubber tubing.
   Two fine needles with stilets.

Four large needles with stilets.
One hemostat.
One long rubber tube with glass connection, to be left in the water with hemostat attached. (Tube should be full of water.) Boil in catheter sterilizer.
One sterile scalpel.
Two sterile test tubes.
One needle threaded with silk.

2. Scrub-up tray.

3. Novocaine one-half percent sol. and sterile hypodermic syringe, per physician's orders.

4. Urine cylinder with Sp. Gr. bulb.

Preparation of Patient.

Apply Tr. of Iodine to area indicated by the physician.

Tracheotomy.

Requisites.

1. Sterile tray containing:
   One scalpel.
   One pr. blunt scissors.
   One hemostat.
   One mouse-tooth forceps.
   One metallic mouth-gag.
   One dilator.
   Three tracheal tubes.
   One probe.
   One bunch pipestem cleaners.
   One small basin boric solution.
   One reel silk sutures.
   One pair thumb forceps.
   One sharp hook.

2. Scrub-up tray.

3. Head mirror and extension light.

4. Sterile rubber gloves for physician.

5. The neck and upper part of chest should be surgically clean.

Notes.

After a tracheotomy, keep a piece of sterile gauze wet in boric solution over the mouth of the tube. The inner tube must be removed and cleansed with sterile pipestem cleaners and boric sol. often enough to keep it free from mucus. After cleansing, *the tube must be replaced immediately.* In case the outer tracheal tube should come out, hold the edges of the incision apart with forceps so the patient can breathe until the tube can be replaced.

Vaginal Examination.

Requisites.

1. Sterile tray containing:
   Bivalve speculum.
   Long uterine tenaculum.
   Uterine dressing forceps.
   One basin bichloride 1-2000.
   Sterile cotton balls.
2. Sterile gloves for physician.
3. Sterile vaseline.

Intra-Uterine Douche.

Requisites.

1. Sterile tray containing:
   Intra-uterine douche nozzle.
   Bivalve speculum.

Uterine dressing forceps.
Long uterine tenaculum.
Twelve sponges.
One piece uterine packing.
Three sterile towels.
One basin bichloride 1:2000.
One basin sterile water.

2. Solution per physician's orders (sterile).
3. Rubber gloves, sterile vaseline.
4. Laparotomy stockings.
5. Kelly pad and pail for solution.

Vaginal Douches.

Give sterile douches, ante- and post-partum and to patients having any vaginal or perineal operative wound.

Pitcher Douches.

Bichloride 1:2000 (always sterile). Give p.r.n. post-partum, to all patients having vaginal or perineal wounds, and after rectal operations where there are external stitches.

Ear Irrigation.

Requisites.

Ear syringe or irrigator and tip.
Required solution at 110° or 112° F. (Temperature should be agreeable to patient.)
Curved basin.
A towel and small rubber.

Notes.

Boil utensils before using. Pull lobe of ear up

and backward. Do not use force. Use at least one pint of solution. Introduce the tip of the irrigator just within the opening into the external canal and direct the stream toward the roof of the canal.

Eye Irrigation.

Requisites.

Solution (per orders) 70-80° F.
Medicine dropper and medicine glass or irrigator and glass tip.
Small rubber and towel. Curved basin.

Notes.

Thoroughly cleanse hands immediately before beginning an eye treatment. Evert lids in all cases except of corneal ulcer or post-operative. Do not let tip touch cornea. Avoid using force. In case both eyes are to be irrigated use separate utensils and scrub hands between irrigations.

Nasal Irrigation.

Requisites.

Irrigator and a large tip.
Three pints solution at 112° F.
Large basin.
Towel and small rubber.

Notes.

Have patient flex head on chest and breathe through mouth. Turn head slightly toward side on which tip is to be introduced. If case is *post-operative,* introduce tip into side opposite to one operated upon. *Do not use force.*

Application of Ointment to Eyes.

1. *To Eyelids.*

If necessary, cleanse margin of lids of all crusts and scales with boric acid solution. Apply ointment with a tightly wrapped cotton toothpick along a line at the base of the lashes.

2. *To Cornea.*

Draw down lower lid, have patient look upward. Apply ointment to inner surface of lower lid with tightly wrapped cotton toothpick or a glass rod.

Hot Compresses to Eyes.

Vaseline the lids before applying compresses. Change q. 30 sec. Test the temperature of the compress before applying or keep the water at 120° F. The compresses are generally applied for fifteen minutes out of one hour. Use forceps for handling compresses; squeeze them out between the folds of a towel. Never use the same compress twice. Never let the compress extend over the bridge of the nose.

Cold Compresses to Eyes.

Change q. 30 sec. If the applications are continued for a long time, vaseline the eyelids before applying them. Use the same general rules as for hot compresses.

Application of Drops to Eyes.

Draw down the lower lid and have the patient look upward. Let the drops fall upon inner surface of lid. Do not let the dropper touch the eye.

Phenol-Sulphone-Phthalein Test.

Routine (per physician's orders).

1. Patient is to have 400 c.c. of water before the test. This is to be repeated if indicated.
2. Have the patient void urine just before the injection of the phthalein.
3. Inject the phthalein into the lumbar muscles. This is not to be done by the nurse.
4. Order total specimens as follows:

10 min.
1 hr. and 10 min.
2 hr. and 10 min.
} following the injection.

5. If there are no contraindications, catheterize the patient if necessary.

Proctoscopic Examination.

Routine (per physician's orders).

1. Omit the preceding meal.
2. S.S. Enema 3 hours before the examination, followed by water enemata until solution is returned clear.

Sugar Tolerance Test.

Routine (per physician's orders).

1. The patient is on usual diet.
2. Omit breakfast.
3. Give Levulose ..... grams at 8 a. m.
4. Hourly specimens to the laboratory as ordered.
5. The patient is to have no food until so ordered.
6. If another test is to be made the next day, the patient is to be put on a carbohydrate free diet.

Routine in Surgical Cases.

1. General.

Charting.

All routine charts are to be B.D. unless otherwise ordered. After operations all charts are to be q. 4 hr. unless otherwise ordered. Special charts are to be kept after every operation until otherwise ordered.

Special Routine for Neurological Cases.

For the first four days after admission take axillary temperature every four hours in both axillæ, using the same thermometer. Keep patient's arms to his sides and leave thermometer in place fifteen minutes. Chart the temperature from the right axilla in red; from the left in black.

For these axillary temperatures use a special chart and keep the ordinary mouth temperature as in other cases. Take the blood pressure of all neurological cases B.D. for the first four days and chart.

Patients will be put on neurological routine only on order of physician.

Bowels.

Cathartics will be ordered by the physician in charge. If the bowels have not moved by 2 p. m. on the day following a cathartic, give as routine a S.S. enema.

2. Routine Preparation for Operation.

Diet.

Soft diet for supper before day of operation. Water freely until 6 a. m.

Bowels.

Castor oil oz. 1 at 6 p. m. the night before operation. (For patient under 15 ask physician for orders as to cathartic.) S.&G. enema at 6 a. m. the morning of operation.

Field of Operation.

Shave the field of operation, if possible giving a margin of at least four (4) inches beyond the probable limits of the incision. Scrub this field for ten minutes with sterile gauze, green soap and sterile water, rinse with sterile water and wash field with alcohol 60 percent, putting on dry sterile dressing. For both male and female, abdominal preparation should include shaving of the hair down to the symphisis pubis. All female patients prepared for abdominal operation are to receive a cleansing vaginal douche bichloride 1:5000 the night before and the morning of the operation. Vaginal preparation includes the removal of all hair from the labia. In scrubbing the perineum substitute bichloride 1:2000 for alcohol.

Before sending the patient to the operating room examine the mouth and remove false teeth and all foreign bodies, as chewing gum, tobacco, etc. Remove all jewelry except wedding rings.

The nurse who takes the patient to the operating room will report to the anesthetist whether or not the patient has recently voided urine (noting time and amount). Patient should void immediately before going to the operating room and the amount and time recorded on the special chart. Send all patients to the operating room on a stretcher.

Emergency Preparation.

Consists of the preparation of the field of operation and if possible the giving of an enema.

Preparation of Head Cases.

Shave the hair until no hair can be felt on passing the hand over the head against the grain. Two shaves are generally necessary after the hair has been clipped as closely as possible. The head should be shaved for the last time in the morning. The nurse should have the physician indicate the area to be shaved on a woman's head. The hair that remains should be braided as tightly as possible and pinned up with a safety pin in such a way that the braid is flat against the head. If there are any abrasions or infected areas of the scalp the same should be reported to the doctor in charge. Whenever possible the *cathartic* is given two nights before the operation. *Light diet* is given the day before the operation. Special attention must be given to the cleansing of the mouth before operation upon the hypophysis.

Order for operation or for anesthesia discontinues all previous orders.

3. Post-Operative Treatment.

On the table, by an ether patient, have a pair of tongue forceps, a wooden mouth gag, a curved basin, and cut gauze.

While the patient is recovering from an anesthetic never leave him for a minute, until he is conscious.

Keep him warmly covered and do not let him aspirate mucus and vomitus.

See that there is plenty of fresh air in the room.

If the patient has not voided ten hours after operation, notify the physician.

Never put a hot water bottle in the bed of an unconscious patient, without permission.

Diet for Post-Operative Cases.

After Laparotomy (unless otherwise ordered). For the first *12 hours* post-operative, nothing by mouth. Then if the patient is not nauseated begin with sips of hot water. If well tolerated increase the amounts and give cold as well. *First* and *second* days increase amounts and on the second day add any liquids.

Morning of the third day give soft solids.

Morning of the fourth day give light diet.

Morning of the fifth day give house diet with care, increasing gradually to full house diet.

Individual cases will require modification from time to time. Any unusual difficulty is to be reported to the ward physician.

Cases not Laparotomy.

Liquids for 18 hours after operation, gradually increasing to regular diets by second and third day.

Rectal Routine.

Liquids without milk, four days. Tr. Opium Deod, m. 1. to 10 t.i.d. or lead and opium pills as ordered. At ten a. m. on the fourth (4th) day give castor oil oz. one (1) and a high oil enema oz. six (6) to be retained and followed in one (1) hour by a soapsuds enema.

Then give soft solids increasing gradually to house diet.

Buck's Extension.

Requisites.

Pulley, rope, slides and weights.
Adhesive plaster and bandages.
Two long strips of adhesive with buckles attached.
Splints, per physician's orders.
Non-absorbent cotton.
Bed cradle.

Prepare leg by shaving. Wash and dry thoroughly.

Plaster Paris Casts.

Requisites.

Plaster bandages.
Sheet wadding bandages.
Basin of warm water (add dr. 1 salt—pints 2 of water).
Large rubber sheet.
Newspapers spread over floor.
To prepare the leg, wash, dry well and powder.

Note.

If too much salt is added, the plaster will not dry.

Pillow Splint.

Requisites.

Three covered splints.
One feather pillow with rubber and muslin covers.
Four straps with buckles.
Sand bags.

Medical and Surgical Routine for Ophthalmoscopic Examination.

To be followed when doctor orders "Prepare for Ophthalmoscopy."

(1) Night before examination (8 p. m.) 3 per-cent homatropine gtts. ii in each eye.

(2) Repeat day of examination at 8 a. m.

(3) Repeat at 11 a. m.

(4) Repeat at 1 p. m., and q. 5 min. thereafter for five doses.

(5) Ophthalmoscope at bedside at 2 p. m.

Gynecological Routine.

Diet.

Supper—soft solids.
Breakfast—nothing.
Water freely up to 6 a. m.

Medicines.

Castor oil 1 oz. at 4 p. m. the day before the operation (18 hours before). S.S. enema the next morning if the patient has not had a bowel movement. Between 4 and 5 a. m. give a colon irrigation until the water returns clear. Give morphia sulphate gr. ¼ and atropia sulphate gr. 1-100 hypodermatically 45 minutes before time set for operation.

Bladder.

Send a specimen of urine to the laboratory the morning of operation.

See that the bladder is emptied immediately before the patient is sent to the operating room.

Catheterize the patient if necessary. Note the quantity of urine and the time voided on the chart.

Field for Abdominal Operation.

Make the preparation of the field the evening before the operation. Shave the abdomen and pubic region. The patient should be bathed after being shaved. Scrub the abdomen for ten minutes with green soap, sterile water and gauze. Rinse thoroughly with sterile water, wash with alcohol, dry and apply a dry dressing. Give the patient a douche of 1:5000 bichloride solution, the evening before the operation. In cleansing the surface, scrub from the center (site of incision) outward.

The morning of operation repeat the bichloride douche 1:5000. Scrub the pubic and external genitals with sterile water and green soap, rinse thoroughly with bichloride solution 1:2000, and apply dry sterile dressings.

Before sending a patient to the operating room, observe the general rules that are followed in all surgical cases.

Post-Operative Treatment in Abdominal Operations.

Water.

Proctoclysis (drop method) one (1) pint every four hours for the first twenty-four hours; one (1) pint every eight hours for the second twenty-four hours. Then discontinue unless otherwise ordered.

Nothing by mouth until 4 p. m. (when operation 9-11 a. m.) After 4 p. m. the patient may be given hot water in small amounts (½ ounce to 2 ounces) every ½ hour if desired. The next morning substitute cold water and increase the amount if desired. If hot water is not retained try cracked ice.

Vomiting.

If vomiting occurs, turn the patient well over on right side and prop in that position that vomitus may escape freely from mouth and not drop into larynx.

Catheterization.

Send a specimen of urine to the laboratory the morning after the operation.

Do not catheterize the patient without an order from the physician.

In all cases requiring repeated catheterization, irrigate bladder with boric acid solution (3 percent) after one of the catheterizations each day and send one specimen to the laboratory each day.

Nourishment.

No nourishment for eighteen (18) hours after operation. Then begin liquid nourishment including albumens, malted milk, clear broths, etc. Give no milk for three days.

Bowels.

Rectal tube may be introduced whenever gas is troublesome.

Sitting Up.

After the bowels have moved well, encourage the patient to move about in bed and to sit up in bed

as much as she likes, more and more each day. This rule as to early exercise in bed applies to ordinary cases in which the abdominal wound has been completely closed. In other conditions, for example where there is drainage, marked weakness, fever, aversion to getting up, or other complications, ask the physician as to getting up.

Post-Operative Treatment.

General Care.

After vaginal operation the care is practically the same as after abdominal operation, with the following exceptions.

Drainage.

In recording, on the bedside notes, the patient's condition when she comes from the operation, note whether or not a piece of gauze has been left in the vagina. This information may be obtained from the physician who comes from the operating room with the patient.

Also make a note when gauze is removed.

Diet.

In simple curettage, repair of cervix or of pelvic floor, the patient may be allowed liquid nourishment the morning after operation and solids the following morning, gradually increasing to regular diet.

Obstetrical Nursing.

Waiting Patients.

1. *Breasts.*

The breasts and nipples of all waiting patients are to be scrubbed daily with soap and water. Ap-

ply special glycerine and alcohol mixture to nipples per physician's orders. Nipples of patients admitted during labor are to receive such attention as may help prepare them for nursing.

2. *T.P.R.*

Take and record temperature, pulse, and respiration, B.D., unless otherwise ordered.

3. *Bath.*

All waiting patients are to have a cleansing bath daily.

Patients in Labor.

1. *Notification of Physician.*

Notify House Officer of the onset of symptoms of labor in any waiting patient and the admission of a patient in labor.

2. *Bath.*

A patient in labor may have a tub bath, before rupture of the membranes. Braid hair if possible and put on a gown with opening in back.

3. *Bowels.*

Give S.S. Enema early and thorough enough to cleanse the lower bowel. (Not given without an order from the head nurse or night superintendent.) Do not give Enema after there is three fingers dilatation without an order from the physician in charge.

Preparation for Vaginal Examination or Delivery.

1. No examination of a patient, supposedly or possibly in labor before proper preparation is completed.

2. Preparation.

(a.) Shave pubic hairs.

(b.) Scrub pubic region to level of umbilicus, upper and inner part of thighs and external genitalia, with green soap and sterile water. Pay particular attention to the folds around labia and prepuce. Clean from before backward. Discard sponges that have passed over the anal region. Rinse with sterile water and flush off with a pitcher douche of bichloride 1:2000.

(c.) Keep genitals covered with large dry sterile dressing until examination is made.

(d.) When examination is to be made or the patient is in the second active stage, flush and swab perineum as often as necessary and replace dry dressing with a sterile towel.

(e.) Have gloves boiled and in bichloride solution 1:2000.

Outfit for Delivery.

Have ready the following:

1. Gloves boiled in bichloride 1:2000.

2. Soaking-up bowl (for hands) of bichloride 1:2000.

3. Sterile table containing:

a. Basin of sterile water and one of bichloride 1:2000.

b. Basin of boric sol. 4 percent.

c. Tray with sterile instruments.
   One pair straight scissors.
   One pair obstetrical forceps.
   One pair umbilical scissors.
   Two curved clamps.
   One rubber catheter.
d. Two pieces linen tape (twelve inches).
e. Gauze sponges.
f. Cotton balls.
g. Towels.
h. Basin for placenta.

4. Sterile table with the following sterile dressings:

a. Leggings.
b. Towels.
c. Cord dressings.
d. Perineal pads.
e. Quilted bed pads.
f. Doctor's gowns.
g. Baby binder.

5. Repair outfit in dry sterile wrapper.
   a. Needle holder.
   b. Perineal needles.
   c. Straight scissors.
   d. Tissue forceps.
   e. Clamps (2 pr.)
   f. Suture material; catgut—2 tubes of No. 2-20 day.

6. Sterile olive oil for cleansing baby.

7. Anesthetic outfit.
   a. Ether.
   b. Ethyl chloride.
   c. Chloroform in dropper bottle.

d. Chloroform mask.
e. Curved basin.
f. Two towels.
g. Tongue forceps.
h. Mouth wedge.
i. Cold cream.
j. Cut gauze.

8. Hypodermic tray complete with the addition of the following:
   a. Ernutin.
   b. Infundin or pituitary liquid.
   c. Narcophin.
   d. Scopolamine (stable).

9. Fluid extract of ergot and a medicine glass.

Care of Patients During Labor.

1. *T.P.R.*

Take temperature, pulse and respiration, every two hours during progress of labor, except when "twilight sleep" is administered.

2. *Bladder.*

Have patient void urine frequently. If she is unable to void and the bladder becomes distended, the house officer in charge should be notified. Do not allow the patient to go to the toilet after labor is in active progress.

3. *Confinement in bed.*

After a patient in labor has been examined by the House Officer, she is to be kept in bed until further notice.

4. *Nourishment.*

Orders for the diet of a patient in labor are to be obtained from the House Officer in charge.

5. *Nursing Care.*

Patients must not be left alone during second stage of labor. Vaginal and abdominal examinations made by students or pupil nurses will be supervised by the House Officer in charge.

Adequate and comprehensive notes must be kept of each patient in labor.

Care of the Patient After Third Stage of Labor.

1. *Confinement in Bed.*

If there has been excessive bleeding or an extensive perineal repair, keep patient on her back with the legs close together for the first twelve hours. If there are no contraindications, the patient may be turned during the first twelve hours to be made comfortable.

After the fifth day, under normal conditions, patient should be encouraged to exercise in bed. Normal cases may be allowed to sit up on the eighth day. No patient is to be allowed out of bed until so ordered.

2. *Uterus.*

Watch uterus closely after the expulsion of the placenta. (Whenever necessary, i. e., if uterus is not well contracted, keep hand on the fundus for one hour.)

Constant massage, squeezing and pressure on the uterus is not necessary in most cases.

Examine perineal pad frequently to judge as to the amount of bleeding. *If bleeding is excessive* and uterus is not well contracted, fluid extract ergot drams 1 *may be given without an order.*

Notify the House Officer in charge at once, in case of post-partum hemorrhage. A nurse should stay with the patient, massage the uterus, and send someone else for the physician.

If an hour after delivery the uterus is well contracted, put patient on the bed-pan and expel the clots from the uterus (proceed as for the expulsion of the placenta). Then comfortably and snugly apply an abdominal binder. Securely pin the perineal pads to the binder.

3. *Diet.*

Give water freely if patient is not nauseated. Liquid diet for three days or until bowels have moved well. Then gradually increase to house diet (per physician's orders).

4. *Bowels.*

Usually castor oil will be ordered the morning of the third day.

5. *Bladder.*

Eight (8) or ten (10) hours after delivery, the patient should be encouraged to void urine. Twelve (12) hours after delivery if the patient has been unable to void and is uncomfortable from a distended bladder, notify the House Officer in charge. On the tenth (10th) day a clean voided specimen of urine is to be sent to the laboratory.

6. *T.P.R.*

Take T.P.R. one hour post-partum and q. four hours for ten days. If the temperature rises to 100° F., take it q. two (2) hours unless otherwise ordered.

After the 10th day, if temperature is normal, take it B.D.

7. *Care of the Perineum.*

Pads are to be changed q. four (4) hours for first five days, later p.r.n. When changing pads, or after micturition or defecation give warm pitcher douche of bichloride 1:2000.

Any unusual condition of the perineum or lochia should be reported to the House Officer.

8. *Care of Breasts.*

Sore, cracked or fissured nipples are to be brought to the attention of the physician in charge.

Large, pendulous and heavy breasts may be supported with a binder and pads, not tight enough to exert much pressure, or preferably may be held up to the median line by a strip of adhesive plaster.

Breasts are not to be pumped or massaged without a written order.

9. *Medication.*

Give ergot mixture drams 1, three times a day, after meals (t.i.d., p.c.) for ten (10) doses.

Routine Examination During Puerperium.

Requisites.

Basin of bichloride 1:2000.
Cotton balls.
Sterile gloves.

Examinations are made only for special reasons.

Bowels should have been well moved recently and the bladder emptied just before the examination.

Nursery Routine.

1. *Care of the New Born Baby.*

Following the birth.

After the baby's eyes have been treated by the physician in charge with one percent silver nitrate solution, the baby, if warm and vigorous, is oiled.

Keep baby *warm* and avoid exposure.

Do not remove the cord dressing applied by the physician and maintain its aseptic character. Weigh the baby (without clothing) and record the weight on the nursery record. Take and record the temperature.

2. *Daily Care.*

Morning bath.

Weigh baby at this time. Cleanse eyes and eyelids with boric acid solution and sterile sponges.

Inspect the mouth carefully and cleanse s.o.s. with boric acid solution.

At the time of the bath do not remove the binder except as necessary until after the cord is off and the scar is dry. Any abnormality or unusual condition about the body, e. g., atresia ani, eruptions, bleeding, sore mouth, difficulty in nursing, etc., is to be noted on the nursery record.

3. *Care of the Cord.*

If a cord is not doing well and if it has not separated at the end of a week, call the attention of the physician to the same. Keep cord dressing dry.

4. *Water.*

Give baby an abundance of warm sterile water from a sterile bottle and nipple. When baby is on regular nursing schedule it should have at least an ounce of water in morning and afternoon.

5. *Nursing Schedule.*

The mother is not to be put on a nursing schedule until she has had a rest period. Babies born in the a. m. may be nursed once or twice during the p. m. before seven (7) but not during the first night. The following a. m. the regular nursing schedule is to be observed, viz.: 6—9 a. m., 12 noon—3—6—10 p. m., 2 a. m.

6. *Nursing Procedure.*

Cleanse nipples with boric solution and sterile cotton before and after nursing. Babies are to be changed before being taken to mothers. Babies are to be taken back to nursery promptly after a twenty (20) minute nursing period. Keep nipples covered with a small square of sterile gauze, held in place with adhesive, during the intervals between nursings.

Visiting Nursing on the Obstetrical Out-Clinic.

A new nurse, before beginning her visits, should note the following items:

(1) Keep a daily and exact account of calls made and carfare expended. On the first of each month, an itemized account of calls made and carfare expended is to be submitted to the Social Service Department.

(2) Before starting out on a case the nurse

should read the social history of the patient which is on file in the Social Service office.

(3) The amount the patient is to pay for obstetrical visiting is indicated on the medical history. The pre-natal worker decides the amount that the patient is able to pay and makes the notation. If the pupil nurse does not find this information, she will please consult the Head Nurse of the obstetrical ward. If the patient does not pay the amount agreed upon, the nurse will consult the pre-natal worker.

(4) If the nurse finds a case of extreme destitution, e. g., where the family is without fire or food, she should learn the religion of the family and then telephone at once to the Social Service office, explaining the situation. If the situation can wait until the next day, the nurse should consult the Social Service office in regard to the proper course of action to pursue. If the nurse is at all in doubt about the economic situation of the family, she should consult the pre-natal worker who is in the obstetrical clinic each afternoon.

(5) Each pupil nurse should read the Social Service Annual Report.

(6) The nurse must inform the mother visited of the work of the Post-Natal Department, i. e., that for some time after the physician and nurse have discharged the mother and baby a worker will visit them and follow up the welfare of the baby. If the nurse fails to inform the mother of this important step, she spoils the chance of the Social Service Department doing effective work with the baby. Therefore, each nurse should feel

eager to carry out the responsibility placed upon her while doing visiting nursing on the Obstetrical Out-Clinic.

(7) The nurse should ask the physician what schedule he wishes for the baby's feeding. She will then write out these orders for the mother. If she will then ask in detail each day just when the baby was nursed, she will be doing lasting and important constructive work with that mother. In dealing with patients on the out-clinic it is important to remember that they are without mental training and are extremely ignorant. It is therefore necessary to use infinite patience and to repeat the same directions each day.

Strict Isolation.

(1) No visitors without special permission from the physician.

(2) Visitors should wear gowns.

(3) In the room have a gown, a basin of solution for hands. (Bichloride 1:2000 or lysol ½ percent solution.) Keep a pair of rubber gloves in the solution.

(4) Everything used for the patient must be disinfected. All excreta is disinfected, except when it is ordered sent to the laboratory. In such cases the utensils must be sterilized immediately after use.

(5) The nurse caring for the patient should carry out the following routine. All articles necessary for the patient's toilet should be taken into room before the nurse begins work. The utensil and linen sterilizers should be empty. Wear a

gown and rubber gloves while caring for the patient. At the conclusion of the toilet take out all linen and utensils and put them directly into the sterilizers, being careful to contaminate nothing in the utensil room.

Return at once to the patient's room, put gloved hands through the solution, remove gloves and then the gown, leaving them in the patient's room. Leave the patient's room and then scrub hands thoroughly under running water with green soap and a brush. Wash off hands with alcohol.

Be careful not to contaminate doorknobs, faucets, and keep the hands away from the face and hair. After scrubbing go to the utensil room and turn on the steam into the sterilizers. Great care must be taken not to contaminate the inside of the gown. After the gloves are removed handle only the inside of the gown.

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